Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

INITIAL
PROVIDER APPLICATION FOR LICENSING
Code of Virginia §37.1-183.1

Please use a word processor or print legibly using permanent, black ink. The chief executive officer, director, or other member of the governing body who has the authority and responsibility for maintaining standards, policies, and procedures for the service may complete this application.

1.Applicant Information: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Organization
Name:_____

Mailing Address_____

City:_____ County _____State:_____

Zip:_____ Phone:( )_____

Chief Executive Office or Director. Identify the person responsible for the overall management and oversight of the service(s) to be operated by the applicant.

Name:_____Title:_____

Phone: ( )_____ Fax Number: ( )_____ Email:_____

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2. Organizational Structure: Identify the organizational structure of the applicant's governing body.

Check one(1) of the following:
[] Non-Profit [] For-Profit

***Check one(1) of the following*:**
[] Individual (proprietorship) [] Partnership
[] Corporation [] Unincorporated Organization or Association

Public agency:
[]State []Community Services Board []Other

Identify accrediting or certifying organization from the following:
[] Accreditation Council for Services for People with Developmental Disabilities [] Virginia Association of Special Education Facilities
[] Joint Commission on Accreditation of Health Care Organizations [] Other association or organization:
[] Commission on Accreditation of Rehabilitation Facilities _____

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3. Applicant Parent Company Information: Identify the parent company of person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Name_____
Mailing Address:_____

City:_____ County _____State:_____Zip:_____ Phone:( )_____

Name:_____Title:_____

SERVICE INFORMATION:

Use the list below to identify the service type(s). If the service type(s) is not listed, please note in the service information section.

* **Residential Services**
  Community ICF-MR
  Community Gero-psychiatric
  Crisis Stabilization
  Group Home
  Half-Way House
  Medical Detox and Social Detox
  Residential Community Services
  Residential Respite
  Residential Treatment
  Residential Treatment SA women w/children
  Supervised Living

* **Day Support Services**
  Clubhouse
  Day Support
  Day Treatment
  Intensive Outpatient
  Partial Hospitalization/Ambulatory Detox
  Psychosocial Rehabilitation
  Therapeutic After-School
  Center-Based Respite

* **Supportive In-Home Services (formerly supportive residential)**
  In-Home Services
  In-Home and out-of home Respite
  Mental Health Community Support Services
  Crisis Stabilization

* **Case Management Services**
* **Inpatient Services**
  Psychiatric Unit
  Medical Detox/CD Unit

* **Intensive In-Home Services**

* **Opioid Treatment Services**

* **Outpatient Services**
  Outpatient
  Emergency

* **Sponsored Residential Home Services**

* **Department of Corrections Facilities Services**

* **Intensive Community Services (ICT)**

* **Programs for Assertive Community Treatment (PACT)**

4.Service Information: Complete for each service type offered by the organization to be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. (See Attached for listing of services types.)

Service Type:_____

Service Director _____Phone (__)_____

THIS SERVICE SERVES:

Individuals with single diagnosis (check all that apply):
[] Mental Retardation
[] Mental Illness
[] Substance Abuse

AND/OR

Individuals with multiple diagnoses (check all that apply):
[] Mental Illness/Mental Retardation
[] Mental Retardation/Substance Abuse
[] Mental Illness/Substance Abuse
[] Mental Illness/Mental Retardation/Substance Abuse

[] Individuals receiving services through the Individual and Family Developmental Disabilities Support Waiver

Client Demographics (check all that apply):
[] Male [] Female [] Child [] Adolescent [] Adult [] Geriatric

Accreditation/Certification by:_____

Location(s)

1.Location Name:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____

Zip:_____

Location Manager:_____Phone:( )_____

Directions:_____

_____

2. Location Name:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____ Phone:( )_____

Directions:_____

_____

3. Location Name:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____ Phone:( )_____

Directions:_____

_____

Service Type:_____

Service Director:_____Phone:( )_____

THIS SERVICE SERVES:

Individuals with single diagnosis (check all that apply):

[] Mental Retardation
[] Mental Illness
[] Substance Abuse

AND/OR

Individuals with multiple diagnoses (check all that apply):

[] Mental Illness/Mental Retardation
[] Mental Retardation/Substance Abuse
[] Mental Illness/Substance Abuse
[] Mental Illness/Mental Retardation/Substance Abuse

[] Individuals receiving services through the Individual and Family Developmental Disabilities Support Waiver

Individual Demographics (check all that apply):

[] Male [] Female [] Child [] Adolescent [] Adult [] Geriatric

Accreditation/Certification by:_____

Location(s)

1. Location Name:_____ # of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____ Phone:( )_____

Directions:_____

_____

2. Location Name:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____ Phone:( )_____

Directions:_____

_____

3. Location Name:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____ Phone:( )_____

Directions:_____

_____

Note: If there are additional service types and/or locations please photocopy additional sheets as needed

5. Required Attachments

* Last year's Balance Sheet or three month-line of credit for new providers (§40)
* Working Budget for the year (§40)
* Service Description(s)for each service (§40 & §580C)
* Admission Criteria (§580)
* A schedule of staffing pattern (§590)
* Records management policy (§40 & §870A)
* Position Descriptions (§40 & §410A)
* SCC Certificate (§40)

Certificate of Application

This certificate is to be read and signed by the applicant. The person signing below must be the individual applicant in the case of a proprietorship or partnership, or the chairperson or equivalent officer in the case of a corporation or other association, or the person charged with the administration of the service provided by the appointing authority in the case of a governmental agency.

I am in receipt of and have read the applicable rules and regulations for licensing. It is my intent to comply with the statutes and regulations and to remain in compliance if licensed.

I grant permission to authorized agents of the Department of Mental Health, Mental Retardation and Substance Abuse Services to make necessary investigations into this application or complaints received. I understand that unannounced visits will be made to determine continued compliance with regulations.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

Signature of Applicant:_____Date:_____

Title:_____

If you have any questions concerning the application please contact this office at (804) 786-1747. This application is to be returned to:

Office of Licensing
Department of Mental Heath, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797